

**HOD ACTION: Council on Medical Education Report 2 adopted as amended, and the remainder of the report filed.**

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 02-JUN-21

Subject: Licensure for International Medical Graduates Practicing in U.S. Institutions with Restricted Medical Licenses (Resolution 311-A-19)

Presented by: Liana Puscas, MD, MHS, Chair

Referred to: Reference Committee C  
(, MD, Chair)

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1 INTRODUCTION

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3 Resolution 311-A-19, “Licensure for International Medical Graduates Practicing in U.S.  
4 Institutions with Restricted Medical Licenses,” introduced by the International Medical Graduates  
5 Section (IMGS), and referred by the House of Delegates, asked that our American Medical  
6 Association (AMA) work with the Federation of State Medical Boards (FSMB), the Organized  
7 Medical Staff Section, and other stakeholders to advocate for state medical boards to support the  
8 licensure to practice medicine by physicians who have demonstrated they possess the educational  
9 background and technical skills and who are practicing in the U.S. health care system.

10  
11 Testimony on this item during the 2019 Annual Meeting from an international medical graduate  
12 (IMG) academic physician who has trained many residents and fellows in the United States, but  
13 who is ineligible to obtain a medical license, reflected the impetus for this item. A physician from  
14 Florida testified how that state continues to grapple with the issue of physician immigrants from  
15 Cuba and other countries who do not meet state licensure requirements yet seek to find a way in  
16 which to put their (often considerable) skills to work in their new country in service to patients and  
17 society.

18  
19 BACKGROUND

20  
21 All state medical boards require physicians to have completed at least one year of graduate medical  
22 education (GME) in a residency program accredited by the Accreditation Council for Graduate  
23 Medical Education (ACGME) to be eligible for a full, unrestricted medical license.<sup>1</sup> Some states do  
24 issue limited, restricted licenses that allow a physician to practice, under supervision, in specific  
25 institutions. Some of these physicians are IMGs who not only received their medical education  
26 outside the U.S. but also trained in a specialty and practiced abroad. After immigrating to the U.S.,  
27 these physicians have been able to establish themselves in an institution utilizing one of these  
28 limited, restricted licenses, despite being ineligible for full licensure. Some institutions, however,  
29 have instituted changes to require that all physicians employed by the institution be board certified  
30 or board eligible. This has excluded physicians with restricted, limited licenses who may have been  
31 serving their community for years while contributing to patient care and the medical education of  
32 students and residents.

1 RESTRICTED LICENSES

2  
3 Medical boards issue a variety of licenses other than full, unrestricted licenses. Of relevance, 40  
4 medical boards issue “faculty/educational” licenses; 44 issue “limited/special purpose” licenses,  
5 and 19 issue “institutional practice” licenses.<sup>1</sup> Medical boards may determine the limitations or  
6 conditions of practice under these licenses differently, as well as the educational and/or training  
7 requirements. In addition, the boards use different names for possibly similar types of licenses,  
8 making it challenging to quantify less common license types at the national level. For example,  
9 according to a requested analysis provided by the FSMB, 163 physicians nationwide possess a  
10 license categorized as “teaching.” These licenses are labeled variously, such as “Foreign Teaching  
11 Physicians” or “Distinguished Faculty.” This count could be low considering the variability in how  
12 medical boards categorize and share data for these less common license types.

13  
14 For example, in Washington state, the Washington Medical Commission may “issue a limited  
15 license to a physician applicant invited to serve as a teaching-research member of the institution’s  
16 instructional staff if the sponsoring institution and the applicant give evidence that he or she has  
17 graduated from a recognized medical school and has been licensed or otherwise privileged to  
18 practice medicine at his or her location of origin. Such license shall permit the recipient to practice  
19 medicine only within the confines of the instructional program specified in the application.”<sup>2</sup>

20  
21 Texas offers a faculty temporary license, with similar requirements as Washington, with specific  
22 restrictions concerning the institution that can hire the physician (i.e., certain medical centers,  
23 Texas medical schools, or GME sponsors).<sup>3</sup> The District of Columbia specifically offers licenses  
24 “for foreign doctors of eminence and authority.”<sup>4</sup> New York offers a limited permit that can allow  
25 an IMG without U.S. GME to practice in a nursing home; state-operated psychiatric,  
26 developmental or alcohol treatment center; or incorporated, nonprofit institution for the treatment  
27 of the chronically ill, but only for up to four years.<sup>5</sup>

28  
29 Florida offers a “house physician” license and provides a detailed description of the work that can  
30 be done, all under the supervision of a physician with an active, unrestricted Florida license. The  
31 license for house physicians does not require U.S. GME and seems to have relatively few  
32 requirements, i.e., types of institutions are not specified, nor time limits.<sup>6</sup>

33  
34 BOARD CERTIFICATION REQUIREMENTS

35  
36 The American Board of Medical Specialties (ABMS) acknowledges that there may be acceptable  
37 alternative pathways to initial certification for candidates who have not completed U.S. GME.  
38 Some ABMS member boards recognize alternative pathways, but others do not, due to the  
39 challenges associated with assessing equivalency of training for these medical specialties.<sup>7</sup>

40  
41 The ABMS Position Statement on Alternative Pathways to initial certification defines the guiding  
42 principles for acceptable alternative pathways that do not meet the standard pathway (i.e.,  
43 ACGME-accredited or Canadian-accredited GME). An ABMS workgroup is currently reviewing  
44 the ABMS Position Statement to determine if additional changes are required to ensure continued  
45 clarity.<sup>7</sup>

46  
47 The ABMS stipulates that alternative pathway policies and procedures for initial certification  
48 should:

- 49  
50 1. Be transparent, objective, equitable, and readily available to interested candidates and  
51 stakeholders;

- 1           2. Not be arbitrary or capricious to interested candidates and stakeholders;
- 2           3. Include the assessment of all six of the ABMS/ACGME core competencies;
- 3           4. Include the assessment of professional standing in adherence with the ABMS Professional
- 4           Standing Policy; and
- 5           5. Adhere to Member Boards' existing Board Eligibility policies for both specialties and
- 6           subspecialties, provided those policies adhere to the ABMS Board Eligibility Policies.

7  
8           Sixteen boards offer pathways for internationally trained physicians; in particular, ten boards offer  
9           pathways for physicians practicing in the United States at an ACGME-accredited institution who  
10          are faculty at an ACGME-accredited program and may have achieved a specified academic rank  
11          (from associate to full professor); two boards will accept international training as meeting all of the  
12          training requirements on a case-by-case basis; and four boards will accept international training as  
13          meeting some of the training requirements on a case-by-case basis. Two boards have established  
14          that training in Australia and New Zealand is equivalent to ACGME-accredited training; these  
15          boards will accept candidates who trained in those countries.

16  
17          Twenty-two member boards accept all of a candidate's training in Canada (either accredited by the  
18          Royal College of Physicians and Surgeons of Canada [RCPSC], or by another body acceptable to  
19          the board). Of these, eleven further require that a candidate be certified by the RCPSC or other  
20          Canadian certifying body. Three boards will accept some of a candidate's training in Canada  
21          (either accredited by the RCPSC or by another body acceptable to the board).

22  
23          Regardless of a member board's position on alternative pathways, it is the policy of the ABMS  
24          that, to be eligible for certification in any specialty or subspecialty and to maintain certification, a  
25          physician must have a full and unrestricted license to practice medicine in at least one jurisdiction  
26          in the United States, its territories, or Canada.

## 27 28          EXPLORATION OF ALTERNATIVE PATHWAYS IN MINNESOTA

29  
30          Minnesota's International Medical Graduate Assistance Program, operational since 2016, helps  
31          IMGs in the state obtain residency positions. One aspect of the program includes study of possible  
32          licensure changes that would allow qualified IMGs to practice in Minnesota. The Minnesota  
33          Department of Health, working with the Minnesota Board of Medical Practice and other  
34          stakeholders, proposed two possible strategies in 2018: the creation of an IMG Primary Care  
35          Integration license and an amendment to the medical practice act to include an exemption for  
36          practice in primary care in a rural or underserved area. Objectively qualified IMGs would be able  
37          to practice in areas experiencing primary care shortages without entering U.S. GME. The process  
38          includes passage of all licensure exams, demonstrating at least seven years of medical practice,  
39          participation in a six-month clinical experience, and an assessment that would culminate in a  
40          certificate that would allow work under supervision.

41  
42          The program would require the commitment of an accredited assessor. Another concern is that  
43          these physicians would not be eligible for board certification and may encounter employment  
44          restrictions. Two major stakeholders—the Minnesota Academy of Physician Assistants and the  
45          Minnesota Medical Association—have raised objections, citing concerns over professional role  
46          confusion and a tiered licensure system. The Minnesota Department of Health continues to  
47          research possible licensure changes.<sup>8,9</sup>

1 CURRENT AMA POLICY

2  
3 As shown in the appendix, the AMA has substantial policy that supports full licensure for  
4 practicing physicians, whether U.S. medical school graduates or IMGs, only after completion of at  
5 least one year of GME in the U.S. (see H-255.988 [12] and H-275.934 [2]).

6  
7 Policy H-160.949 (6) specifies as well that the AMA “opposes special licensing pathways for  
8 physicians who are not currently enrolled in an [accredited]...training program.” This policy was  
9 adopted at the 2014 Annual Meeting in response to development in Missouri of a special licensure  
10 pathway for practice by “assistant physicians” who have not had any GME in the U.S. (see  
11 [https://www.aapa.org/news-central/2014/06/american-medical-association-house-of-delegates-](https://www.aapa.org/news-central/2014/06/american-medical-association-house-of-delegates-rejects-assistant-physician-concept/)  
12 [rejects-assistant-physician-concept/](https://www.aapa.org/news-central/2014/06/american-medical-association-house-of-delegates-rejects-assistant-physician-concept/)). Meanwhile, Policy H-275.978 (5) states that the AMA “urges  
13 those licensing boards that have not done so to develop regulations permitting the issuance of  
14 special purpose licenses. It is recommended that these regulations permit special purpose licensure  
15 with the minimum of educational requirements consistent with protecting the health, safety and  
16 welfare of the public.” It would seem that these two policies are contradictory; accordingly, they  
17 are proposed for modification in the recommendations below.

18  
19 In addition, the AMA both recognizes the value of board certification but advocates against  
20 discrimination against physicians based on a lack of board certification. Policy H-220.960 asks The  
21 Joint Commission to “support retention of important medical staff structural standards in its  
22 hospital accreditation programs, including, but not limited to, standards...that board certification is  
23 an excellent benchmark for the delineation of clinical privileges.” At the same time, H-275.926  
24 states that the AMA “(4) Opposes discrimination against physicians based solely on lack of ABMS  
25 or equivalent AOA-BOS board certification, or where board certification is one of the criteria  
26 considered for purposes of measuring quality of care, determining eligibility to contract with  
27 managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining  
28 competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that  
29 may occur against physicians involved in the board certification process, including those who are  
30 in a clinical practice period for the specified minimum period of time that must be completed prior  
31 to taking the board certifying examination.”

32  
33 SUMMARY AND RECOMMENDATIONS

34  
35 Existing AMA policy is of two minds in terms of the requirements for full licensure and board  
36 certification. Indeed, the need for an expanded workforce, to meet the growing needs of patients for  
37 access to health care services, must be balanced with requisite caution in awarding licensure for  
38 practice, given the need to protect the public and ensure the quality of the medical workforce.  
39 Given, however, that physicians who have been serving their communities for years may have their  
40 careers jeopardized as a result of employers adopting new employment standards, the Council on  
41 Medical Education recommends that the following recommendations be adopted in lieu of  
42 Resolution 311-A-19 and the remainder of this report be filed:

- 43  
44 1. That our American Medical Association (AMA) advocate that qualified international medical  
45 graduates have a pathway for licensure by encouraging encourage state medical licensing  
46 boards and the member boards of the American Board of Medical Specialties to develop  
47 criteria that allow 1) completion of medical school and residency training outside the U.S., 2)  
48 extensive U.S. medical practice, and 3) evidence of good standing within the local medical  
49 community to serve as a substitute for U.S. graduate medical education requirement for  
50 physicians seeking full unrestricted licensure and board certification. (Directive to Take  
51 Action)

- 1 2. That our AMA amend Policy H-255.988 (12), “AMA Principles on International Medical  
2 Graduates,” by addition to read as follows:  
3  
4 Our AMA supports ...12. The requirement that all medical school graduates complete at  
5 least one year of graduate medical education in an accredited U.S. program in order to  
6 qualify for full and unrestricted licensure. State medical licensing boards are encouraged to  
7 allow an alternate set of criteria for granting licensure in lieu of this requirement: 1)  
8 completion of medical school and residency training outside the U.S., 2) extensive U.S.  
9 medical practice, and 3) evidence of good standing within the local medical community.  
10 (Modify Current HOD Policy)  
11
- 12 3. That our AMA amend Policy H-275.934 (2), “Alternatives to the Federation of State Medical  
13 Boards Recommendations on Licensure,” by addition to read as follows:  
14  
15 2. All applicants for full and unrestricted licensure, whether graduates of U.S. medical  
16 schools or international medical graduates, must have completed one year of accredited  
17 graduate medical education (GME) in the U.S., have passed all state-required licensing  
18 examinations (USMLE or COMLEX USA), and must be certified by their residency  
19 program director as ready to advance to the next year of GME and to obtain a full and  
20 unrestricted license to practice medicine. State medical licensing boards are encouraged to  
21 allow an alternate set of criteria for granting licensure in lieu of this requirement for  
22 completing one year of accredited GME in the U.S.: 1) completion of medical school and  
23 residency training outside the U.S., 2) extensive U.S. medical practice, and 3) evidence of  
24 good standing within the local medical community. (Modify Current HOD Policy)  
25
- 26 4. That our AMA amend Policy H-160.949 (6), “Practicing Medicine by Non-Physicians,” by  
27 addition and deletion to read as follows:  
28  
29 Our AMA ... (6) opposes special licensing pathways for “assistant physicians” (i.e., those  
30 who are not currently enrolled in an Accreditation Council for Graduate Medical Education  
31 of ~~American Osteopathic Association~~ training program, or have not completed at least one  
32 year of accredited ~~post~~-graduate ~~US~~ medical education in the U.S.). (Modify Current HOD  
33 Policy)  
34
- 35 5. That our AMA amend Policy H-275.978 (5), “Medical Licensure,” by addition to read as  
36 follows:  
37  
38 Our AMA ... (5) urges those licensing boards that have not done so to develop regulations  
39 permitting the issuance of special purpose licenses, with the exception of special licensing  
40 pathways for “assistant physicians.” It is recommended that these regulations permit  
41 special purpose licensure with the minimum of educational requirements consistent with  
42 protecting the health, safety and welfare of the public; (Modify Current HOD Policy)

Fiscal Note: \$1,000.

## APPENDIX

### *H-160.949, "Practicing Medicine by Non-Physicians"*

Our AMA . . . (6) opposes special licensing pathways for physicians who are not currently enrolled in an Accreditation Council for Graduate Medical Education of American Osteopathic Association training program, or have not completed at least one year of accredited post-graduate US medical education.

### *H-220.960, "The Joint Commission Hospital Accreditation Program Standards"*

Our AMA requests its trustees who serve as Commissioners to The Joint Commission to support retention of important medical staff structural standards in its hospital accreditation programs, including, but not limited to, standards requiring that medical staff operate as a self-governing entity - as defined in medical staff bylaws; that physician directors of hospital departments be board certified or possess equivalent qualifications; and that board certification is an excellent benchmark for the delineation of clinical privileges....

### *H-255.966, "Abolish Discrimination in Licensure of IMGs"*

1. Our AMA supports the following principles related to medical licensure of international medical graduates (IMGs):

- A. State medical boards should ensure uniformity of licensure requirements for IMGs and graduates of U.S. and Canadian medical schools, including eliminating any disparity in the years of graduate medical education (GME) required for licensure and a uniform standard for the allowed number of administrations of licensure examinations.
- B. All physicians seeking licensure should be evaluated on the basis of their individual education, training, qualifications, skills, character, ethics, experience and past practice.
- C. Discrimination against physicians solely on the basis of national origin and/or the country in which they completed their medical education is inappropriate.
- D. U.S. states and territories retain the right and responsibility to determine the qualifications of individuals applying for licensure to practice medicine within their respective jurisdictions.
- E. State medical boards should be discouraged from a) using arbitrary and non-criteria-based lists of approved or unapproved foreign medical schools for licensure decisions and b) requiring an interview or oral examination prior to licensure endorsement. More effective methods for evaluating the quality of IMGs' undergraduate medical education should be pursued with the Federation of State Medical Boards and other relevant organizations. When available, the results should be a part of the determination of eligibility for licensure.

2. Our AMA will continue to work with the Federation of State Medical Boards to encourage parity in licensure requirements for all physicians, whether U.S. medical school graduates or international medical graduates.

3. Our AMA will continue to work with the Educational Commission for Foreign Medical Graduates and other appropriate organizations in developing effective methods to evaluate the clinical skills of IMGs.

4. Our AMA will work with state medical societies in states with discriminatory licensure requirements between IMGs and graduates of U.S. and Canadian medical schools to advocate for parity in licensure requirements, using the AMA International Medical Graduate Section licensure parity model resolution as a resource.

*H-255.970, "Employment of Non-Certified IMGs"*

Our AMA will: (1) oppose efforts to employ graduates of foreign medical schools who are neither certified by the Educational Commission for Foreign Medical Graduates, nor have met state criteria for full licensure.

*H-255.988, "AMA Principles on International Medical Graduates"*

Our AMA supports:

6. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.

7. In cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.

12. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure.

*H-275.926, "Medical Specialty Board Certification Standards"*

Our AMA: (4) Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.

*H-275.934, "Alternatives to the Federation of State Medical Boards Recommendations on Licensure"*

Our AMA adopts the following principles: (2) All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all licensing examinations (USMLE or COMLEX USA), and must be certified by their residency

program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine.

*H-275.936, "Mechanisms to Measure Physician Competency"*

Our AMA: (1) continues to work with the American Board of Medical Specialties and other relevant organizations to explore alternative evidence-based methods of determining ongoing clinical competency; (2) reviews and proposes improvements for assuring continued physician competence, including but not limited to performance indicators, board certification and recertification, professional experience, continuing medical education, and teaching experience....

*H-275.978, "Medical Licensure"*

Our AMA: (5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public;



## REFERENCES

- <sup>1</sup> U.S. Medical Regulatory Trends and Actions 2018. Federation of State Medical Boards: 2018.
- <sup>2</sup> Washington State Legislature, RCW 18.71.095. Limited licenses. <https://app.leg.wa.gov/rcw/default.aspx?cite=18.71.095>. Accessed January 7, 2020.
- <sup>3</sup> Texas Medical Board. Faculty Temporary License. [www.tmb.state.tx.us/page/licensing-faculty-temporary-licenses](http://www.tmb.state.tx.us/page/licensing-faculty-temporary-licenses). Accessed September 16, 2019.
- <sup>4</sup> Code of the District of Columbia, § 3–1205.09a. Licenses for foreign doctors of eminence and authority. <https://code.dccouncil.us/dc/council/code/sections/3-1205.09a.html>. Accessed September 16, 2019.
- <sup>5</sup> New York State Education Department. License Requirements. Physician. Limited Permits. [www.op.nysed.gov/prof/med/medlic.htm](http://www.op.nysed.gov/prof/med/medlic.htm). Accessed September 16, 2019.
- <sup>6</sup> Florida Board of Medicine. Resident Physicians, Interns, Fellows, and House Physicians. <https://flboardofmedicine.gov/licensing/resident-physicians-interns-fellows-and-house-physicians/>. Accessed September 16, 2019.
- <sup>7</sup> American Board of Medical Specialties Committee on Certification (COCERT). December, 2020.
- <sup>8</sup> Minnesota Department of Health. International Medical Graduate (IMG) Program. <https://www.health.state.mn.us/facilities/ruralhealth/img/index.html>. Accessed September 16, 2019.
- <sup>9</sup> Hirsi I. Could the state-funded International Medical Graduate Assistance Program do more for immigrant doctors — and help address Minnesota’s looming doctor shortage? MinnPost. May 11, 2018. <https://www.minnpost.com/new-americans/2018/05/could-state-funded-international-medical-graduate-assistance-program-do-more-i/>. Accessed December 30, 2019.